

IRO REVIEWER REPORT - WC

DATE OF REVIEW: 2-24-2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

RS Medical lumbo-sacral orthotic for an injury.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Reviewer, Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Primary Diagnosis Code (ICD)	Date of Injury	Claim Number	Type of Review	Upheld Overturn
724.2	x-xx-xxxx	WCxxxxxxxxxx	Pre-certification	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Physician follow-up office visit notes
RS Medical Prescription for bracing signed on 12-14-2006
Price List RS-LSO Spinal Orthosis Effective February 2006
Pre-authorization Peer Review Form dated 12-28-2006
Notice of Intent to issue an Adverse Determination dated 12-28-2006
Notice of Utilization Review Findings dated 12-29-2006 and 1-4-2007
Request for Authorization for purchase of the RLSO dated 12-21-2006
12-15-2003 Employee Request to Change Treating Physician
received TWCC 1-7-2004

PATIENT CLINICAL HISTORY [SUMMARY]:

x-xx-xx Date of injury, moving boxes
1-14-2004 Employee Request to Change Treating Physician
1-16-2006 Surgery: Lumbar spine fusion L4-S1. No other record found-no surgeon's name, type of surgical approach, type of internal fixations, type of immobilization, etc. No finding from the patient's post-operative course to warrant present request for the above corset device.
11-16-2006 Physician request for RS-LSO Spinal Orthosis for Chronic low back Pain with radiculopathy, Failed back surgery syndrome, Status post Intrathecal morphine pump placement with good pain control and Status post lumbar spine surgery, 1-16-2006, with continued pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Base on clinical experience, I found that there is no demonstrated need for the corset requested. Physician office notes document good pain control with intrathecal morphine pump. There is no post-operative record to warrant the use of corset.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME